

Holistic Healing Arts
Victoria Podlaski, DOMP
Diploma in Osteopathic Manual Practice
Reg #21-415

NAME: _____ DATE: _____

ADDRESS: _____

PHONE #: _____ ALTERNATE PHONE #: _____

EMAIL: _____ DATE OF BIRTH: _____

OCCUPATION _____

HAVE YOU EVER RECEIVED OSTEOPATHIC CARE BEFORE? YES NO

DOES YOUR INSURANCE COVER CONSULTATIONS WITH AN OSTEOPATH? YES NO

NAME OF INSURANCE COMPANY: _____

HOW WERE YOU REFERRED TO OUR CLINIC? _____

MAIN COMPLAINT/REASON FOR VISIT _____

WHAT TYPE OF PAIN? Radiating _____ Dull/achy _____ Sharp _____ Acute _____

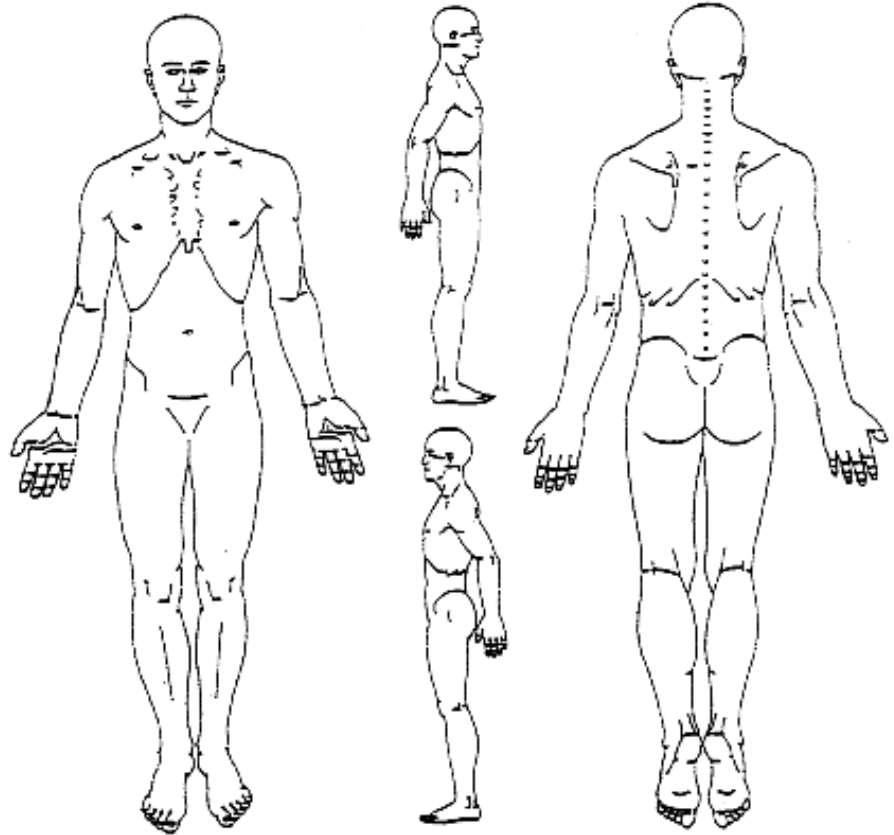
PAIN SCALE 1 2 3 4 5 6 7 8 9 10

Please look at the following list and check off anything that would be relevant to you.

- | | |
|--|--|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Allergies (Oils, Nuts, Fragrances) | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Herniated Disk |
| <input type="checkbox"/> Auto-immune Condition | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Back Pain: <input type="checkbox"/> Upper <input type="checkbox"/> Mid <input type="checkbox"/> Lower | <input type="checkbox"/> Injury: _____ |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Muscle Strain/Sprain |
| <input type="checkbox"/> Cardiac/Circulatory Condition | <input type="checkbox"/> Numbness: _____ |
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Chronic Pain: _____ | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Surgery: _____ |
| <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Skin Condition: _____ |
| <input type="checkbox"/> Decreased Range of Motion | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Whiplash |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Other: _____ |

Please indicate any painful Areas with an "X"

Note any other issues



Injuries Including any Motor Vehicle Accidents - Type and Date

Do you have any Internal Pins/Wires/Dental work/Artificial Joints/Special equipment?

Are you receiving any other health care ie, Chiro, Massage, Physio, and for what?

Anything else you need me to know

I deem all of the above information to be true and comprehensive. I understand that my accurate health history helps the practitioner to treat me in the best and safest manner possible. Omission of any pertinent information on my part may result in a negative reaction or outcome of treatment which my practitioner is not responsible for.

PATIENT NAME: _____ **DATE:** _____

SIGNATURE: _____